STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK, LLC	5011 KESSLER BLVD EAST INDIANAPOLIS, IN46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00093579. Complaint IN00093579 - Substantiated. State deficiencies related to the allegation are cited at R052, R091, R214 and R349. Date of Survey: August 9, 2011 Facility number: 010064 Provider number: 010064 AIM number: N/A Survey Team: Mary Jane G. Fischer RN Census bed type: Residential: 52 Total: 52 Census payor type: Other: 52 Total: 52 Sample: 4 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review 8/15/11 by Suzanne Williams, RN	R0000	The following is the plan of correction for Brookdale Place of Fall Creek in regards to the complaint survey IN00093579 conducted on August 9, 2011. This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions in the statement of deficiencies or any related sanction fine. Rather it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigation factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review, observation and interview, the facility failed to ensure residents were free from physical abuse, in that when resident A wandered into the room of resident B, resident B pushed resident A, who fell to the floor and sustained a fractured wrist. This deficient practice involved 2 of 4 sampled residents. [Residents A and B]. Findings include: The record for resident B was reviewed on 08-09-11 at 10:15 a.m. Diagnoses included, but were not limited to, senile dementia, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility, the resident resided on the second floor; however, as the resident began to display behaviors which included exit seeking, the resident was moved to the secured dementia unit. The record also indicated the resident had been seen by the psychiatrist for an initial	R0052	052***What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?*** In response to this finding, Resident B was assessed for continued appropriateness of placement at this community through the resident personal service assessment and plan completed by the Health and Wellness Director on 8/18/11. Specific interventions were added to her personal service plan and these interventions were documented for care givers via the Care Profile and resident specific assignment sheet. In response to the event itself, Resident B had been referred to the psychiatric specialist serving our community for evaluation. She has been seen at least monthly for several months. Medical exam was completed 7-14-11 (within 24 hours of alleged incident). Most recent psych evaluation was completed on August 3, 2011 with recommendations and med adjustments reviewed with family. . Resident A was immediately assessed for physical injuries by the nurse and was sent to the ER for treatment,	08/31/2011

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	evaluation on 02-07-11 and then had subsequent visits by the psychiatrist or the nurse practitioner on 04-06-11, 05-04-11, 06-08-11, 07-06-11 and 08-03-11. The initial evaluation indicated the resident did not have the potential to "harm" others. Further review of the psychiatric notations indicated the resident was observed as "quite loud, argumentative and threatening to staff, sobbing loudly, yelling." The psychiatrist indicated during the 06-08-11 session the resident had dementia with depression and behaviors with intermittent outbursts. However, the 08-03-11 notation indicated "asked to see for [arrow pointing upward] agitation. Recently pushed peer who had wandered into room, breaking peer's wrist. Can be difficult to redirect." The "resident log," dated 07-13-11 at 9:40 p.m., indicated "Res. [resident] had [arrow pointing upward] agitation this shift. Family aware." On 08-09-11 at 10:15 a.m., resident A was observed wandering throughout the dementia unit. The resident had a cast on the right arm. During interview on 08-09-11 at 10:20 a.m., Certified Nurse		following physician and family notification. She was sent back with a splint and later casted due to resident self-removal of splint. Resident A was observed for any changes of condition and her personal service plan was reviewed by the HWD. No changes in care needs were indicated as a result of the fracture, as resident was already receiving the same level of care after the incident as she was prior to the incident. ***How will the facility identify other residents with the potential to be effected by the same alleged deficient practices and what corrective action will be taken to ensure the alleged deficient practice does not recur?*** Unit nurse and HWD will audit all current residents for aggressive behavior in the past 30 days and up date personal service plans as indicated. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?*** HWD initiated one on one in-service training with licensed staff immediately to assure all understood the policy and procedure for abuse prevention and with particular attention to documentation indicating what specifically was done to protect other residents when one resident appears agitated. A staff in-service for Resident Rights and Abuse	

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	Aide employee "F" indicated the resident "broke wrist during a fall." Review of the facility provided "Incident Report," on 08-09-11 at 12:00 p.m., indicated the following: "Incident date: 07-13-11, incident time 10:00 p.m. [Name of Resident A] was wandering about the memory care unit and entered [Name of Resident B] room. [Name of Resident B] became agitated and shoved [Name of Resident A] telling [resident] to get out of [resident] house. [Name of Resident A] fell ...wrist was swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of resident B] was redirected. The staff monitored [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] is scheduled to be assessed by the residence Geripsych physician. A visual stop aid was places <sic> on [Name of Resident B] door to deter wandering residents from entering." During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified Resident B pushed Resident A when Resident A wandered into room. "They're [in reference to the employees] are supposed to separate the		Prevention is scheduled for August 26 th . During daily staff meetings the HWD, Clare Bridge (Memory Care neighborhood within Brookdale Place) unit manager and Clare Bridge nurse will review any incident reports for aggressive behavior and make the necessary referrals and/or implement appropriate behavior management techniques per individual needs. Individual Resident Care Profiles will be updated where indicated and copies made available for review by caregivers. ***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put in place?*** During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all updates and interventions are included on the service plan and assignment sheets. ***By what date will these systemic changes be implemented?*** August 31, 2011 052***What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?*** In response to this finding, Resident B was assessed for continued appropriateness of placement at this community through the resident personal service assessment and plan completed	

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	residents and monitor them." Review of the facility policy titled "Abuse Prevention Program Policy," undated, on 08-09-11 at 2:00 p.m. indicated the following: "[Blank] dedicated to the prevention of resident abuse. The center uses the following program to ensure every effort is made to prevent abuse. ... 6. Protecting residents from any further abuse by B. ... 2) one on one supervision or emergency transfer of any resident suspected or allegedly accused of abuse." Review of the facility policy titled "Abuse, Neglect and Exploitation Reporting and Investigation," dated 06-16-2006 on 08-09-11 at 2:00 p.m., indicated the following: "Policy [bold type] Brookdale is committed to maintaining a safe environment to each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Administrator and or Executive Director or the supervisor on duty for investigation and appropriate follow-up." "Response to Incident [bold type] - a. Protection of Resident [underscored].		by the Health and Wellness Director on 8/18/11. Specific interventions were added to her personal service plan and these interventions were documented for care givers via the Care Profile and resident specific assignment sheet. In response to the event itself, Resident B had been referred to the psychiatric specialist serving our community for evaluation. She has been seen at least monthly for several months. Medical exam was completed 7-14-11 (within 24 hours of alleged incident). Most recent psych evaluation was completed on August 3, 2011 with recommendations and med adjustments reviewed with family. . Resident A was immediately assessed for physical injuries by the nurse and was sent to the ER for treatment, following physician and family notification. She was sent back with a splint and later casted due to resident self-removal of splint. Resident A was observed for any changes of condition and her personal service plan was reviewed by the HWD. No changes in care needs were indicated as a result of the fracture, as resident was already receiving the same level of care after the incident as she was prior to the incident. ***How will the facility identify other residents with the potential to be effected by the same alleged deficient practices and what corrective***	

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	Upon learning of alleged abuse, neglect or exploitation, Administrator and or Executive Director or supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending. ... c. Resident on Resident Contact [underscored] - If an incident involves resident on resident contact, both residents should be evaluated for a changed of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident assessment and Service Plan should be updated as appropriate." The facility was unable to provide documentation the policy was followed in regard to the protection of other residents from further abuse. This State Finding relates to complaint IN00093579.		***action will be taken to ensure the alleged deficient practice does not recur?*** Unit nurse and HWD will audit all current residents for aggressive behavior in the past 30 days and up date personal service plans as indicated. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?*** HWD initiated one on one in-service training with licensed staff immediately to assure all understood the policy and procedure for abuse prevention and with particular attention to documentation indicating what specifically was done to protect other residents when one resident appears agitated. A staff in-service for Resident Rights and Abuse Prevention is scheduled for August 26 th . During daily staff meetings the HWD, Clare Bridge (Memory Care neighborhood within Brookdale Place) unit manager and Clare Bridge nurse will review any incident reports for aggressive behavior and make the necessary referrals and/or implement appropriate behavior management techniques per individual needs. Individual Resident Care Profiles will be updated where indicated and copies made available for review by caregivers. ***How will the corrective actions be monitored to ensure the***	

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			deficient practice will not recur, i.e. what quality assurance programs will be put in place? During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all updates and interventions are included on the service plan and assignment sheets. ***By what date will these systemic changes be implemented?*** August 31, 2011	
R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review, observation and interview, the facility failed to ensure their policy was implemented, in that when a resident [B] displayed behaviors which resulted in physical abuse by one resident to another resident [A], the nursing staff failed to implement the facility policy related to the protection of residents from further abuse, for 1 of 1 resident who displayed physical abuse in a sample of 4. [Resident B]. Findings include: The record for resident B was reviewed	R0091	*091* ***What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?*** In response to alleged incident, Resident B was redirected and monitored by staff to assure there was no further danger of resident to resident altercation. In this incidence, the resident was easily redirected and went to bed for the night without further incident. Resident was sent to the Med-Check the following day for medical evaluation, and subsequently seen by	08/31/2011

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	on 08-09-11 at 10:15 a.m. Diagnoses included but were not limited to senile dementia, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility, the resident resided on the second floor; however, as the resident began to display behaviors which included exit seeking, the resident was moved to the secured dementia unit. The record also indicated the resident had been seen by the psychiatrist for an initial evaluation on 02-07-11 and then had subsequent visits by the psychiatrist or the nurse practitioner on 04-06-11, 05-04-11, 06-08-11, 07-06-11 and 08-03-11. The initial evaluation indicated the resident did not have the potential to "harm" others. Further review of the psychiatric notations indicated the resident was observed as "quite loud, argumentative and threatening to staff, sobbing loudly, yelling." The psychiatrist indicated during the 06-08-11 session the resident had dementia with depression and behaviors with intermittent outbursts. However, the 08-03-11 notation indicated		geriatric specialist on August 3 rd for follow-up. In response to this finding, Resident B was assessed by the physician for continued appropriateness of placement on the Memory Care Unit. The resident's personal service plan was updated and completed on 8/18/11. Specific interventions were added to her personal service plan and these interventions were provided for care givers via the Resident's Care Profile and resident specific assignment sheet. ***How will the facility identify other residents with the potential to be effected by the same alleged deficient practices and what corrective action will be taken to ensure the alleged deficient practice does not recur?*** To assure that no other residents are lacking the proper documentation of aggressive events, the unit nurse and HWD will review incidents for the past 30 days and should any other incidents involve resident to resident altercation, the HWD will audit documentation and update the Resident's Personal Service Plan accordingly. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?***	

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	"asked to see for [arrow pointing upward] agitation. Recently pushed peer who had wandered into room, breaking peer's wrist. Can be difficult to redirect." The "resident log," dated 07-13-11 at 9:40 p.m., indicated "Res. [resident] had [arrow pointing upward] agitation this shift. Family aware." On 08-09-11 at 10:15 a.m., resident A was observed wandering throughout the dementia unit. The resident had a cast on the right arm. During interview on 08-09-11 at 10:20 a.m., Certified Nurse Aide employee "F" indicated the resident "broke wrist during a fall." Review of the facility provided "Incident Report," on 08-09-11 at 12:00 p.m., indicated the following: "Incident date: 07-13-11, incident time 10:00 p.m. [Name of Resident A] was wandering about the memory care unit and entered [Name of Resident B] room. [Name of Resident B] became agitated and shoved [Name of Resident A] telling [resident] to get out of [resident] house. [Name of Resident A] fell ...wrist was swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of		Associates will be re-educated on "How to handle aggressive Behaviors" by the HWD/Designee on August 26 th , 2011. During daily staff meetings, the HWD/Designee, Clare Bridge (Memory Care Neighborhood within Brookdale Place) unit manager and Clare Bridge nurse will audit events involving aggressive behavior to complete documentation on the Personal Service Plan, Care Profile and add to assignment sheet where indicated. ***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put in place?*** During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all incident reports are complete ***By what date will these systemic changes be implemented?*** August 31, 2011	

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	resident B] was redirected. The staff monitored [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] is scheduled to be assessed by the residence Geripsych physician. A visual stop aid was places <sic> on [Name of Resident B] door to deter wandering residents from entering." During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified Resident B pushed Resident A when Resident A wandered into room. "They're [in reference to the employees] are supposed to separate the residents and monitor them." Review of the facility policy titled "Abuse Prevention Program Policy," undated, on 08-09-11 at 2:00 p.m. indicated the following: "[Blank] dedicated to the prevention of resident abuse. The center uses the following program to ensure every effort is made to prevent abuse. ... 6. Protecting residents from any further abuse by B. ... 2) one on one supervision or emergency transfer of any resident suspected or allegedly accused of abuse." Review of the facility policy titled "Abuse, Neglect and Exploitation Reporting and Investigation," dated as			

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	revised 06-16-2006, on 08-09-11 at 2:00 p.m., indicated the following: "Policy [bold type] Brookdale is committed to maintaining a safe environment to each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Administrator and or Executive Director or the supervisor on duty for investigation and appropriate follow-up." "Response to Incident [bold type] - a. Protection of Resident [underscored]. Upon learning of alleged abuse, neglect or exploitation, Administrator and or Executive Director or supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending. ... c. Resident on Resident Contact [underscored] - If an incident involves resident on resident contact, both residents should be evaluated for a changed of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident assessment and Service Plan should be updated as appropriate."			

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	The facility was unable to provide documentation the policy was followed in regard to the protection of other residents from further abuse. This State Finding relates to complaint IN00093579.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure their policy was implemented, in that when a resident displayed behaviors which included physical abuse to another resident, the nursing staff failed to update the assessment and service plan for 1 of 4 records reviewed. [Resident B]. Findings include: The record for resident B was reviewed on 08-09-11 at 11:00 a.m. Diagnoses included, but were not limited to, senile dementia, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review. The initial assessment and service plan was dated 01-17-11.	R0214	*214* ***What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?*** In response to alleged incident, Resident B was redirected and monitored by staff to assure there was no further danger of resident to resident altercation. In this incidence, the resident was easily redirected and went to bed for the night without further incident. Resident was sent to the Med-Check the following day for medical evaluation, and subsequently seen by geriatric specialist on August 3 rd for follow-up. Personal Service Plan and Care Profile were updated on August 18 th , by the HWD. Plan was reviewed with family following discussion about medication adjustments.	08/31/2011

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	At the time the resident was admitted to the facility, the resident resided on the second floor; however, as the resident began to display behaviors which included exit seeking, the resident was moved to the secured dementia unit on the third floor. The record also indicated the resident had been seen by the psychiatrist for an initial evaluation on 02-07-11 and then had subsequent visits by the psychiatrist or the nurse practitioner on 04-06-11, 05-04-11, 06-08-11, 07-06-11 and 08-03-11. The initial evaluation indicated the resident did not have the potential to "harm" others. Further review of the psychiatric notations indicated the resident was observed as "quite loud, argumentative and threatening to staff, sobbing loudly, yelling." The psychiatrist indicated during the 06-08-11 session the resident had dementia with depression and behaviors with intermittent outbursts. However, the 08-03-11 notation indicated "asked to see for [arrow pointing upward] agitation. Recently pushed peer who had wandered into room, breaking peer's wrist. Can be difficult to redirect."		***How will the facility identify other residents with the potential to be effected by the same alleged deficient practices and what corrective action will be taken to ensure the alleged deficient practice does not recur?*** To assure that no other residents may be lacking appropriate interventions for aggressive behavior on the service plan, the unit nurse and HWD will review all current residents for aggressive behavior in the past 30 days and update personal service plans as needed. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?*** Associates will be re-educated on “Dealing with Residents with Aggressive Behaviors” on August 26 th , 2011 by the HWD/Designee. During daily staff meetings the HWD, Clare Bridge (Memory Care neighborhood within Brookdale Place)Unit Manager and Clare Bridge nurse will review any incident reports for aggressive behavior and make the necessary referrals and/or implement appropriate behavior management techniques per individual needs. ***How will the corrective actions be monitored to ensure the deficient***	

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		A. BUILDING 00 B. WING	08/09/2011

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	The "resident log," dated 07-13-11 at 9:40 p.m., indicated "Res. [resident] had [arrow pointing upward] agitation this shift. Family aware." Review of the facility provided "Incident Report," on 08-09-11 at 12:00 p.m., indicated the following: "Incident date: 07-13-11, incident time 10:00 p.m. [Name of Resident A] was wandering about the memory care unit and entered [Name of Resident B] room. [Name of Resident B] became agitated and shoved [Name of Resident A] telling [resident] to get out of [resident] house. [Name of Resident A] fell ...wrist was swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of resident B] was redirected. The staff monitored [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] is scheduled to be assessed by the residence Geripsych physician. A visual stop aid was places <sic> on [Name of resident B] door to deter wandering residents from entering." During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified Resident B pushed Resident A when Resident A wandered		***practice will not recur, i.e. what quality assurance programs will be put in place?*** During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all updates and interventions are included on the service plan and assignment sheets. ***By what date will these systemic changes be implemented?*** August 31, 2011	

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	into room. "They're [in reference to the employees] are supposed to separate the residents and monitor them." Review of the facility policy titled "Abuse, Neglect and Exploitation Reporting and Investigation," dated as revised 06-16-2006, on 08-09-11 at 2:00 p.m., indicated the following: "Policy [bold type] Brookdale is committed to maintaining a safe environment to each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Administrator and or Executive Director or the supervisor on duty for investigation and appropriate follow-up." "Response to Incident [bold type] - a. Protection of Resident [underscored]. Upon learning of alleged abuse, neglect or exploitation, Administrator and or Executive Director or supervisor on duty should attempt to take necessary steps to ensure that resident are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending. ... c. Resident on Resident Contact [underscored] - If an incident involves resident on resident contact, both residents should be evaluated for a changed of condition.			

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	Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident assessment and Service Plan should be updated as appropriate." Further review of the Resident B's record lacked an updated "Personal Service Assessment" or "Service Plan" related to the physical abuse displayed which resulted in a physical injury to another resident and documentation of the implementation of preventative measures to discourage further physical outbursts. This State Finding relates to complaint IN00093579.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to ensure complete clinical records in that when a resident [B] displayed behaviors which included physical abuse towards another resident [A] which resulted in a fracture,	R0349	*349* ***What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?***	08/31/2011

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	the nursing staff failed to document completed details related to Resident B continued behaviors or the implementation of monitoring of Resident B for additional or ongoing abusive acts, or complete details related to the circumstances related to the injury sustained by Resident B, for 2 of 4 sampled residents. [Residents A and B]. Findings include: Review of the facility provided incident report on 08-09-11 at 12:00 p.m., indicated the following: "Incident date: 07-13-11, incident time 10:00 p.m. [Name of Resident A] was wandering about the memory care unit and entered [Name of Resident B] room. [Name of Resident B] became agitated and shoved [Name of Resident A] telling [resident] to get out of [resident] house. [Name of Resident A] fell ...wrist was swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of resident B] was redirected. The staff monitored [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] is scheduled to be assessed by the residence Geripsych physician. A visual stop aid was places <sic> on		Resident B's family and physician were indeed notified of the incident but that fact the physician was notified was not recorded. Documentation of physician follow-up through Med Check visit on 7/14/11 is now on the chart along with documentation of gero-psych visit from 8/3/11. ***How will the facility identify other residents with the potential to be effected by the same alleged deficient practices and what corrective action will be taken to ensure the alleged deficient practice does not recur?*** To assure that no other residents are lacking the proper documentation of notification of family members and physicians ,the unit nurse and HWD will audit all such events for the past 30 days and should any other incidents involve resident to resident altercation, the HWD will assure that there is proper documentation of notification of family members and physician for any resident displaying aggressive behavior toward another. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?*** During daily staff meetings the HWD, Clare Bridge (Memory Care) unit manager and Clare Bridge nurse will review any incidents involving alleged aggressive behavior and	

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	[Name of resident B] door to deter wandering residents from entering." The record for Resident B was reviewed on 08-09-11 at 11:00 a.m. Diagnoses included, but were not limited to, senile dementia, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility, the resident resided on the second floor; however, as the resident began to display behaviors which included exit seeking, the resident was moved to the dementia locked unit. The "resident log," dated 07-13-11 at 9:40 p.m., indicated "Res. [resident] had [arrow pointing upward] agitation this shift. Family aware." The record lacked documentation of the physical aggression displayed by resident B toward another resident. The record for resident A was reviewed on 08-09-11 at 10:15 a.m. Diagnoses for resident A included, but not limited to, dementia and open reduction and internal fixation of the left hip. These diagnoses remained current at the time of the clinical record review.		assure there is proper documentation of notification of family and physician. . ***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put in place?*** During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all necessary notifications have been made. ***By what date will these systemic changes be implemented?*** August 31, 2011	

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	On 08-09-11 at 10:15 a.m., resident A was observed wandering throughout the dementia unit. The resident had a cast on the right arm. During interview on 08-09-11 at 10:20 a.m., Certified Nurse Aide employee "F" indicated the resident "broke wrist during a fall." Review of the resident record indicated the following: "07-13-11 10:00 p.m. - Res. [resident] found on floor in hallway moaning and holding right wrist. Res. assist times 2 staff [arrow pointing upward]. Right wrist bruising/swelling. Notified [name of physician] Received order 3 view right wrist d/t [due to] pain/swelling. Notified [name of local x-ray company." The record lacked documentation the resident sustained the injury related to physical abuse displayed by resident B. During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified resident B pushed resident A when resident A wandered into the room. "They're [in reference to the employees] are supposed to separate the residents and monitor them." The Health and Wellness Director confirmed the record lacked documentation the Resident had been monitored.			

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	Review of the facility policy titled "Abuse Prevention Program Policy," and undated, on 08-09-11 at 2:00 p.m. indicated the following: "[Blank] dedicated to the prevention of resident abuse. The center uses the following program to ensure every effort is made to prevent abuse. ... 6. Protecting residents from any further abuse by B. 2) one on one supervision or emergency transfer of any resident suspected or allegedly accused of abuse." Review of the facility policy titled "Abuse, Neglect and Exploitation Reporting and Investigation," dated as revised 06-16-2006, on 08-09-11 at 2:00 p.m., indicated the following: "Policy [bold type] Brookdale is committed to maintaining a safe environment to each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Administrator and or Executive Director or the supervisor on duty for investigation and appropriate follow-up." "Response to Incident [bold type] - a. Protection of Resident [underscored]. Upon learning of alleged abuse, neglect or exploitation, Administrator and or			

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	Executive Director or supervisor on duty should attempt to take necessary steps to ensure that resident are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending. ... c. Resident on Resident Contact [underscored] - If an incident involves resident on resident contact, both residents should be evaluated for a changed of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident assessment and Service Plan should be updated as appropriate." "External Reporting/Notification [bold type] - b. Notifying Physician [underscored]. The Administrator and or Executive Director or supervisor on duty should notify the resident's physician if there is an allegation of resident abuse, neglect or exploitation. ... (2) Notification and attempts at notification should be documented in the Resident Log." This State Finding relates to complaint IN00093579.			